REVIEW OF ESSENCE OF CARE

JUNE 2007

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ACKNOWLEDGEMENTS

NIPEC are grateful to all those who have taken part in this review, particularly Nurse Directors, senior nurses and practice development facilitators from across the HPSS, independent and voluntary sector. Thank you for taking the time to complete the questionnaires in detail that enabled analysis of this work to be undertaken. We hope the findings and recommendations set out in this report offer helpful guidance on future regional work around this important topic.

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EXECUTIVE SUMMARY

Essence of Care benchmarking is a quality improvement activity aimed at improving care standards and quality. It is a process of comparing, sharing and developing practice in order to achieve and sustain 'best' practice. The Essence of Care toolkit was introduced by the Department of Health in England during 2001 and was adopted soon after in Northern Ireland. During 2004 the DHSSPS commissioned NIPEC to lead the regional Essence of Care project working with a wide range of statutory and independent organisations to facilitate and evaluate the implementation of the benchmarks.

The purpose of this review has been to evaluate the progress being made across Northern Ireland since 2005. The review consisted of a Part 1 questionnaire sent to colleagues who had responsibility for facilitating the implementation of the benchmarks in their area since 2004 and Part 2 questionnaire sent to Nurse Directors to evaluate any organisational development in relation to Essence of Care benchmarks. Part 2 also evaluated the impact of the benchmarking process on patient experience. Content analysis was used to analyse questionnaire responses.

The findings of the current review do indicate that the majority of Trusts appear to be undertaking at least some Essence of Care work. It is evident however that recommendations from the 2005 review of Essence of Care remain largely unaddressed. For example there would appear to have been limited widespread progress on capacity building at the leadership and facilitation level to support benchmarking work, minimal evidence of multi-disciplinary learning to support benchmarking, and a continuing lack of organisational commitment to the process in some areas. There has also been a limited amount of ongoing monitoring and evaluation of the impact of this work or that individual benchmarks were being rolled out between organisations or compared with other areas regionally, in the way the Essence of Care toolkit had been designed.

The most successful aspects of local benchmarking have been themed into six categories – local area improvements; better information and awareness; impact on training and development of staff; better service provision; greater collaboration between disciplines; and environmental improvements.

Results from the Part 1 survey also indicated that organisational challenges to the establishment, implementation and sustainability of Essence of Care are linked to a lack of multidisciplinary focus for this work; time restrictions; lack of commitment to the process; competing priorities; inability to meet resource implications and lack of knowledge of and confidence in the benchmarking process. Respondents offered a range of suggestions for improving the utilisation of Essence of Care across Northern Ireland including having nominated champions in each organisation, adopting a regional framework approach to benchmarking to include standardisation of audit tools and methods for sharing good practice.

In Part 2 of the review, analysis of questionnaire returns indicated that levels of satisfaction regarding the successful adoption of the Essence of Care toolkit vary greatly. The main difficulties being reported were a lack of leadership and ownership of the process at a practice level; difficulties obtaining consensus regarding 'best practice' at a multidisciplinary level; competing priorities in relation to other quality improvement work; and the challenge of sustaining this work within existing resources, at times without an apparent supportive organisational infrastructure. It is evident that Essence of Care remains lacking in the context of organisational priorities and strategic planning, and while a fair number of respondents indicated that this work is part of their organisational governance framework, there is limited evidence that this is being undertaken in a rigorous and systematic way.

In response to the findings of this review, NIPEC make eight recommendations aimed at improving the implementation and sustainability of Essence of Care. They cover key factors around leadership, local facilitation, regional and local prioritisation, resource procurement, awareness, training, evaluation and sharing good practice.

SECTION ONE

INTRODUCTION

1.0 'The Essence of Care' was commissioned by the Department of Health in England in 2001 to support measures to improve quality, set out in 'A First Class Service' (DoH, 1998) and to contribute to the introduction of clinical governance at local level. The benchmarking process outlined in the original Essence of Care toolkit helped practitioners to take a structured approach to sharing and comparing practice, enabling them to identify the best and to develop action plans to remedy poor practice in eight fundamantal areas of care – continence, bladder and bowel care; personal and oral hygiene; food and nutrition; pressure ulcers; privacy and dignity; record keeping; safety of patients with mental health needs in acute mental health and general hospital settings; and principles of self care. In 2002 work was undertaken to develop further benchmarks, and these were later published under the headings of communication and promoting health (DoH, 2003). All of the ten benchmarks were then presented in a revised format that took into account the experience of those who had been using the original Essence of Care toolkit.

1.1 Essence of Care has enabled health care personnel to work with patients to identify best practice, and to develop action plans to improve care. All sets of benchmarks are interrelated and complement each other, for example, there are elements of privacy and dignity that link with continence and bladder and bowel care. Ideally patients, carers and practitioners work together to agree and describe good quality care and best practice. The benchmarks have been tested, refined and endorsed nationally during a process of consensus agreement involving patients, professional and user group representatives.

SECTION TWO

BACKGROUND

2.0 The Mater Hospital Trust pioneered Essence of Care benchmarking work in Northern Ireland, commencing this activity in 2001 and continuing to-date. Most of the remaining Trusts as well as organisations from outside the HPSS commenced this initiative between 2002 and 2005. During 2004 the DHSSPS in Northern Ireland commissioned NIPEC to lead the regional Essence of Care project through working with a wide range of statutory and independent organisations to facilitate and evaluate the implementation of the benchmarks. This initiative was successful and in May 2005, fifty-four Essence of Care projects from across Northern Ireland were presented at a conference to share key learning and discuss the challenges of taking this work forward (See Appendix 1 for a List of all fifty four Projects). Projects were undertaken across 16 HPSS Trusts, 5 Nursing Homes, Marie Curie Cancer Care and the Prison Nursing Service. The Northern Ireland Essence of Care Steering Group encouraged organisations to *'build on the progress to date, by demonstrating and sustaining improvements' in the patient's experience of care'.*

2.1 A comprehensive evaluation of the 2004-05 project indicated a need for specific issues to be addressed in order to sustain and take forward Essence of Care in Northern Ireland, including:

- Addressing training needs among staff involved in this activity
- Providing resources to implement necessary changes as a result of the benchmarking process
- Managing the tendency for Essence of Care activities to compete with other quality initiatives
- Consider the value of forming regional groups to address benchmarking e.g. tissue viability, infection control, health promotion
- Addressing the importance of 'protected time' at the practice level.

2.2 It was identified that the level of awareness of Essence of Care varied and understanding of the toolkit and benchmarking process was challenging for many. Despite this, there was a widespread commitment to improving standards of care and these have since been reflected in the DHSSPS Quality Standards (2006). These reflect the potential for utilising the Essence of Care benchmarking process as a means of improving the delivery of safe and effective services. Strong leadership was also crucial to the success of the project and one of the essential factors for achievement was to ensure that benchmarking work was given a high priority, led from the top of the organisation and regularly placed as an agenda item on senior management meetings. Three other important findings from the 2005 evaluation referred to the need to commit resources to Essence of Care through funding local facilitation for the project, ensuring that the toolkit was part of all pre-and-post registration nursing and midwifery education and the need to develop methods for sharing the outcomes of benchmarking activity. The original review concluded by recommending that organisations *'promote a culture of person-centred care by incorporating the principles of Essence of Care into organisational strategies for quality improvement'*. In the period since this time, not only does Essence of Care[1] continue to provide an excellent organisational tool for practice and quality improvement, but it should increasingly be seen as beneficial to enable organisations to performance manage the service being provided for patients across these ten fundamental areas of care.

Purpose of the NIPEC REVIEW

2.3 The purpose of this review has been to evaluate the progress being made across Northern Ireland by a range of healthcare providers during their continued implementation of the Essence of Care benchmarks in the period 2005-2007. NIPEC recognises the value of Essence of Care benchmarking activities in improving quality standards and patient experience. We were therefore keen to examine how this

[1] NIPEC has developed an online practice and quality development database available at www.nipec.n-i.nhs.uk which contains a number of Essence of Care projects from throughout Ireland.

work had progressed, developed and if there were indicators of sustainable improvements.

APPROACH USED FOR THE REVIEW

2.4 We utilised a questionnaire survey undertaken in two parts because we wanted to find out not only how each project had progressed, but also if the Essence of Care activities had become imbedded in the organisation and been further developed. Therefore we decided to question project leads from the original project and then Directors of Nursing in the eighteen Trusts. The part one questionnaire was designed to assess four factors about the progress of the original Essence of Care work (reported at the regional conference in 2005):

- The current status of this work
- The most successful benchmarking areas
- The most challenging aspects of this work and the reasons for this
- Other issues of relevance to the success of delivering Essence of Care.

2.5 The Part 1 questionnaire (see copy in the Appendix 2) was issued during December 2006, to those managers or practitioners who had responsibility for facilitating the implementation of the benchmarks in their area. Twenty-two questionnaires representing fifty-four regional benchmarking projects were sent to organisations who had taken part in the original work. A few Trusts had focused on delivering against most of the ten benchmarks, while the majority of organisations had concentrated on implementing several of these. Twenty questionnaires were returned completed, referring to forty two projects, an excellent response rate of over 90%.

2.6 The Part 2 questionnaire (see Appendix 3) was sent out to evaluate the most recent organisational developments in relation to Essence of Care and to assess its position within organisational strategy,

operational policy and in particular governance. Part two also evaluated the impact of the benchmarking process as a quality improvement tool and drew focus on whether or not this was improving actual patient experience. This questionnaire was sent to Directors of Nursing in the eighteen HPSS Trusts during February 2007. Eleven questionnaires were returned, a reasonable response rate of 60%.

SECTION THREE

FINDINGS

3.0 The findings of this review are presented in two parts to reflect the information gained from each of the questionnaires. Both questionnaires provided respondents with an opportunity to give comments alongside each answer thereby offering a qualitative element to the study which resulted in a more meaningful review. A process of 'content analysis' was used to analyse the findings. This is an accepted method in qualitative research, often used to reduce narrative information into themed categories. A series of recommendations are offered after the presentation of results to enable Executive Nurse Directors and other organisational leads to consider how they might take forward Essence of Care in their areas.

3.1 PART 1 RESULTS

The questionnaire asked respondents to indicate the name of the project lead for Essence of Care according to each benchmark area, the date of commencement for this work, current status of this activity, completion date (if appropriate), and information on how the benchmarking has been evaluated. Table 1 in the appendices provides information in respect of the above questions, and this is summarised as follows.

3.2 Information on forty-two benchmarks was returned in twenty questionnaires from across Northern Ireland. Most of the Trusts as well as organisations from outside the HPSS commenced Essence of Care work between 2001 and 2005. Several Trusts would appear however, to have undertaken no reportable work on Essence of Care. The benchmarks used most often have been privacy and dignity (8 projects regionally), nutrition (12 projects), and pressure ulcers (5 projects). The least utilised would appear to have been the self care and promoting health benchmarks. The majority of projects were completed during the last two years. Some reported ongoing action planning and

implementation of these, a few projects are under review, however there was little evidence that individual benchmarks were being rolled out between organisations or compared with other areas regionally, in the way the Essence of Care toolkit had been designed. In a few cases the learning from benchmarking activity in one clinical setting had led to improvements across the organisation. In one Trust for example, the benchmark for nutrition has now been implemented across all in-patient wards, with the MUST nutritional screening tool being used to assess the nutritional status of all new patient admissions.

3.3 There appeared to be a limited amount of ongoing monitoring and evaluation of the impact of the benchmarking process in most areas. While Essence of Care was designed to be rolled out organisationally and to promote benchmarking between service providers in different areas, it would seem that the majority of projects undertaken in Northern Ireland have been site specific and restricted to a single action planning process. The majority of work reported has indicated *'some evidence'* of evaluating their benchmarking activity through audits, and a few organisations have used a range of methods to evaluate the impact of this work in a more systematic way e.g. through undertaking quarterly audits, observing practice, satisfaction surveys, monitoring complaints, service reviews and so on. However most have reported *'not having robustly'* evaluated their Essence of Care work.

3.4 **Successful aspects of local benchmarking work**

The Part 1 questionnaire asked respondents to indicate the range of success factors that had been achieved in their area as a result of the benchmarking process. These have been divided into the six themed categories:

- local area improvements
- better information and awareness
- impact on training and development of staff
- better service provision

- greater collaboration between disciplines
- environmental improvements.

Local area improvements

The analysis of returned questionnaires provides indication of a very wide range of 'local area improvements' as a result of Essence of Care benchmarking. Improvements are wide ranging and include, reduced waiting times, reductions in clinic non-attendances, clear evidence of improved patient experience and local service user engagement in the planning and improvement process. Appendix 4 provides some examples regionally for how the privacy and dignity benchmark has not only led to striking improvements for patients and carers, but if rolled out regionally could enhance the experience of many people who receive health care.

Better information and awareness

There were many examples of how Essence of Care work led to better information and awareness in relation to a range of factors. For example, in one area using the continence benchmark, standard information on what to expect at the clinic, is now sent to all clinic attendees prior to their first visit thus improving patient awareness and understanding. In another area, work on the privacy and dignity benchmark resulted in staff becoming much more aware of the impact of their behaviours on others. For example patient's confidentiality is promoted through better use of screens in clinical settings to maintain individual privacy. Investigation gowns have been improved to prevent exposure and locks on treatment room doors have been added. Policy guidance for each of the above is now in place. Information for patients and their families on the prevention and management of pressure ulcers has now improved and in another Trust that is looking at the needs of clients with mental health needs in the acute setting, a communication group has been established to regularly review the appropriateness of information patients receive.

Impact on training and development

There was evidence that Essence of Care activities has impacted on staff training and development. In one area, all health visitors and school nurses are now offered training in relation to enuresis on an ongoing basis. Another Trust has written Essence of Care into their organisational learning and development programme to encourage its use as evidence of self development. In relation to the prevention of pressure ulcers, at least one Trust has used the learning achieved from the benchmarking process to highlight and address the need for more appropriate training on screening and assessment of risk in patients. Another Trust ensures that Essence of Care is part of staff induction. Encouragingly this is a multi-disciplinary training approach and has been attended by a wide range of nursing, medical and therapy staff.

Better service provision

There was evidence that a wide range of improved service provision had been achieved as a result of Essence of Care activity. Questionnaire analysis appears to indicate that this has been achieved as a result of the leadership being given to the benchmarking process in specific areas, the resulting focus on assessing and improving fundamental aspects of care, the development of staff in relation to quality improvement and a local commitment to the work being undertaken. Some areas have been able to engage carers and patient support groups to maximise local involvement in the benchmarking process and where benchmarking has been most successful the leadership given has enabled a patient focused and structured approach to developing, sharing and comparing best practice. One example of improved service provision in relation to the nutrition benchmark has resulted in:

- Introduction of the MUST[2] nutritional screening tool (across a number of Trusts)

[2] Malnutrition Universal Screening Tool is a well validated assessment tool and involves patients in planning for their nutrition from the moment of admission, with advice on how to continue when well

- Establishment of protected meal times
- Improved communication links between ward, catering and hotel services with regard to ordering and monitoring food provision
- Provision of dental screening
- Review of fridge-freezer facilities to facilitate storage of food for patients with special dietary needs.

Greater collaboration between disciplines

A number of respondents to this review have reported that Essence of Care is often seen as a 'nursing project' and as a result has not been given the multi-disciplinary consideration it requires. Analysis of the Part 1 questionnaire has provided clear indication that successful benchmarking activity appears to be enhanced when professional groups work together and particularly when the work is informed by patient and public involvement. In one Trust respondents reported that *'the nutrition benchmark was only successful as a result of dietetic input'* which they identified was a key factor in the collaboration required to undertake more holistic and comprehensive assessment for patients. In another area a Trust-wide complaints forum had been established that included service user representation. The communication benchmark was being used to begin a multi-disciplinary assessment of performance in this area. This process was chaired by a non-executive director. Another Trust had improved communication across the multi-disciplinary team as a result of Essence of Care. Examples of this have included the development of a protocol to guide staff on how best to negotiate the involvement of carers, sharing of and discussion around audit feedback, improved referral arrangements and increased understanding of respective roles and the impact this has on delivering patient care across the multi-disciplinary team.

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again. The tool was developed and published by the British Association for Parenteral and Enteral Nutrition.

Environmental improvements

A number of the benchmark projects appear to have led to environmental improvements. These tend to relate to the privacy and dignity, food and nutrition and safety of clients with mental health needs in the acute mental health and general hospital settings. Examples in the mental health context include improvements to reception area, sitting room and ward dining room, installation of a new resource room to facilitate patients and staff in accessing information and more appropriate use of local community facilities. In the same Trust, developments in the environment of a stroke unit have led to increased frequency in the checking of cleanliness in toilet areas, installing of mixer taps for patients with impaired dexterity and the development of a pictorial aid to overcome language difficulties. It is clear from the range of improvements offered that small changes have the potential to make a big difference, but only if they have been transferred to other areas.

3.5 Challenges to the establishment, implementation and sustainability of Essence of Care

The remaining questions in the Part 1 questionnaire asked respondents to describe any challenges they had experienced as an organisation in relation to the successful establishment, implementation and sustainability of Essence of Care benchmarking. The challenges faced by those leading on or taking part in benchmarking work have been divided into six themed categories as follows:

- lack of multidisciplinary focus
- time restrictions
- lack of commitment to the process
- competing priorities
- inability to meet resource implications
- lack of knowledge of and confidence in the benchmarking process.

Lack of multidisciplinary focus

As noted earlier, a number of respondents reported that Essence of Care is very much seen as a nursing project and largely the responsibility of nurses to implement. Linked to this, one of the main challenges facing teams has been finding ways to successfully engage and involve staff from other disciplines who may have no knowledge of Essence of Care, but who are often critical to the successful implementation and sustainability of this work. Some Trusts have experienced a lack of interest from other professional colleagues e.g. *'we tried but received little response or interest from occupational therapy, physiotherapy and support staff such as IT and audit'.*

Time restrictions

It was interesting to note that one of the main challenges to the benchmarking process appears to have been *'finding the time to take this work forward'.* A number of organisations stated that time to attend meetings and the tension between *'committing to taking part in a project group versus the priority of giving care to patients'* was a barrier they often experienced. One Trust said that Essence of Care was one example of *'additional and expected work that was required to be done within an already busy work schedule'*, however *'only two hours had been allocated on a monthly basis to attend project meetings'.* Another organisation stated that they faced a *'major challenge to enable staff to find suitable time for groups to meet in order to contribute effectively to the benchmarking process'.*

Competing priorities

It is evident from the questionnaire results that staff interested in taking forward benchmarking work do face the challenge of meeting competing priorities, both at the level of service delivery and through requirements to undertake other quality improvement work. Staffing issues as a result of changing levels of sickness and absenteeism, commitments to training, education and other personal development initiatives can reduce the amount of time given to Essence of Care.

One Trust stated that the *'benchmarking had not been as successful as we had hoped as the challenge of 'Cleanliness Matters' has overtaken it in priority, among other competing demands on the time of ward staff'*. Other organisations indicated similar barriers to this through, for example, having to concentrate on government priorities such as *'reducing delayed discharges and waiting lists'*.

Lack of commitment to the benchmarking process

It is evident from the range of responses to the questionnaire that a *'lack of local ownership'* and commitment to Essence of Care is one of the main barriers faced by those attempting to champion this work. Some Trusts have reported difficulties *'keeping staff motivated and enthusiastic about the process'*, *'maintaining interest and momentum for this'* and the problems they have had *'sustaining interest with other workload pressures experienced by staff and managers'*.

Inability to meet resource implications

Undertaking Essence of Care successfully requires a wide range of resource acquisition, which many organisations have acknowledged was not always in place and therefore a common barrier to sustaining the process. Resource issues ranged from a *'lack of funding to appoint a clerical offer for the project'*, *'lack of resources to implement the proposed actions from the review process'*, and *'lack of dedicated audit department support and assistance towards the monitoring and evaluation process'*. As noted earlier, protected time for staff to take part in project meetings has been a resource challenge for many, as was the level of resource required to change documentation and fund new approaches to care delivery that were required in response to recommendations from the benchmarking process.

Lack of knowledge of and confidence in the benchmarking process

It has been a common view of respondents that the benchmarking process is a challenge for many and requires an investment in training, facilitation and ongoing project support for its successful

implementation and sustainability. One organisation stated that *'the initial challenge for the project groups was in relation to gaining an understanding of the Essence of Care document as the benchmarking process was a new concept for most'*. Another Trust experienced *'difficulty establishing and staff accepting their work on the project area, and a related frustration in agreeing on the level of compliance with practice indicators'*. The benchmarking documentation proved troublesome for many, some of whom claimed that *'a great deal of effort was required to clarify the details of the documentation as the indicators were often very repetitive'*. Similarly *'some of the benchmarks within the toolkit were repetitive and time consuming, which led to unnecessary duplication among factors that could easily have been integrated'*.

3.6 Suggestions for improving the utilisation of Essence of Care across Northern Ireland

Part 1 of the questionnaire concluded by inviting respondents to offer any particular suggestions they might have to assist development work in this area. An interesting range of responses was returned and have been summarised as follows:

- *"It would be helpful to have named Essence of Care 'champions' in each area to provide the leadership and facilitation skills required to enable this work to be successful. This should include a DHSSPS/HSCA and organisational lead in each area";*
- *"Standardised baseline audit tools would be seen as very beneficial, as this would reduce variations in what is being assessed for each benchmark";*
- *"A regional approach to benchmarking between organisations would be welcomed as a means of formalising the sharing of best practice";*
- *"Essence of Care should be given the level of regional priority it requires, be seen as compulsory in each organisation and*

organised appropriately in all areas through its integration with Trust quality and governance work plans";

- *"It would be helpful to have the guidance of a regional framework for Essence of Care to help introduce and sustain this work, and through facilitating common practice in the areas of service review, identifying and using best practice, audit and evaluation approaches, documentation and reporting mechanisms".*

3.7 PART 2 RESULTS

The second part of this review consisted of a questionnaire (see appendix 3) sent to Directors of Nursing in each of the eighteen HPSS Trusts in Northern Ireland, and aimed at evaluating the current status of Essence of Care in their areas. Nine questions were asked and the responses to these summarised as follows:-

Question one asked respondents how satisfied they had been with the progress of the Essence of Care benchmarking work undertaken in their organisation?

Of the eleven Trusts who completed this questionnaire, one organisation has been very satisfied with their benchmarking work, six have been satisfied, and four dissatisfied. Most Trusts have undertaken at least some implementation of two or more benchmarks in specific areas. One Trust said that they were *'satisfied with what has been achieved and the standard of approach that was undertaken in implementing the Essence of Care indicators for food and nutrition'*. Another Trust claimed that *'there has been an excellent response from the multidisciplinary team to the benchmarks undertaken to-date. Staff are committed to ensuring high standards within their practice'*. The barriers to sustaining this work were highlighted in Part 1 findings, however many Trusts continue to be committed to taking forward this process. One Trust, for example, stated that *'progress has been very slow due to competing demands at ward level'*. Another said that *'there was significant investment in facilitating Essence of Care at the outset*

of the project, however this has been difficult to sustain due to competing priorities'.

Question two asked what the 'main challenges' they had faced regarding the introduction and implementation of Essence of Care benchmarks were?

Responses to this question were very similar to a related question in Part 1 of the review. The following difficulties were echoed:

- Lack of leadership and ownership of the process at a practice level
- Difficulties obtaining consensus regarding 'best practice' within the multidisciplinary forum
- Lack of a supportive infrastructure to facilitate this aspect of practice and quality improvement work
- Competing priorities in relation to other project work required to address ministerial targets
- The regional drive and level of facilitation by NIPEC was a major *'enabling factor'* for this work. Once this ceased organisations *'struggled to maintain this work'*
- The challenge of supporting and sustaining projects within existing resources.

Question three asked had they been able to expand Essence of Care project work across their organisation?

In response to this question, seven Trusts stated that they had expanded their benchmarking work organisationally, while four said that they had been unable to do so. One Trust reported that in addition to continuing work to implement all of the benchmark areas, they had been in contact with another local Trust and two Trusts in England to share areas of good practice and further the level of comparison and benchmarking. Another area noted that *'many good initiatives have*

resulted from the work in Cardiology on the food and nutrition benchmark. A trust-wide group has now been formed to consider this work on a wider scale and thereby make widespread improvements across the Trust'. One Trust that had so far been unable to expand the benchmarking process noted that *'this work has now been incorporated within the strategy for nursing to bring about changes in the culture and context of care to enable such work to be owned and taken forward by practitioners. This will be supported and facilitated by senior nurses and will therefore form part of the overarching principle of developing person-centred care'*. The challenge for the above organisation has been to incorporate Essence of Care benchmarking as an *'integral component of the overall drive for quality'*, and not to be viewed as a separate or additional piece of work. One other positive development organisationally relates to how the recommendations from the food and nutrition comparison group has contributed to the re-establishment of the 'Food and Nutrition Group' in one Trust which is chaired by the Head of Nutrition and Dietetics. This initiative has *'enabled staff to pilot and introduce a coloured lid system which identifies patients requiring assistance at meal times'*.

Question four asked respondents whether Essence of Care had been 'required' in the following six strategic and operational planning areas:

- **Listed in the Director of Nursing's objectives** – eight stated that Essence of Care was in their objectives, although for some this was self imposed; three did not have Essence of Care in their objectives.
- **Listed as organisational priorities for action** – four said that they were, while seven said that they were not.
- **Prioritised within the Trust Delivery Plan and performance management arrangements** – four stated that Essence of Care

was in their Trust Delivery Plan, while seven reported that this was not the case.

- Part of the organisational governance framework – seven indicated that this was the case, while four said it was not.
- Part of the organisational quality plan and/or clinical audit programme – nine Trusts stated that it was, while two said that it wasn't.
- Part of the risk management programme within the organisation – it was for four Trusts, but was not in the case of seven Trusts.

Given that only eleven of eighteen HPSS Trusts completed the questionnaire, the above analysis from the eleven Trusts who are actively pursuing this work indicates that the level of organisational priority being afforded to this work appears weak.

Question five asked 'who was leading Essence of Care in their organisation'.

In four of the eleven Trusts who responded, this leadership was the responsibility of the Director of Nursing, sometimes in partnership with a practice development or senior nurse. In two Trusts the Assistant Director of Nursing was leading this work. Other levels of responsibility were delegated to an area manager, lead nurse, quality improvement manager or practice development nurse.

Question six asked 'whether or not Essence of Care had a multidisciplinary focus across the Trust'.

Ten of the eleven Trusts indicated that this was the case. A number of examples were provided to show how this was being achieved, for example, in mental health this was involving nursing, medicine, A&E, social services, governance and audit department, and service users. The food and nutrition benchmark in another Trust involved nursing, dietetics, catering, dental services, speech and language services,

clinical governance team and patient support staff. One more example in the area of privacy and dignity in an outpatient's department involved representation from nursing, medicine, radiography, physiotherapy, records and information department, clinical and social care governance team.

Question seven asked respondents to describe the type of organisational support being given to Essence of Care

Answers to this question revealed that this is being achieved in a wide range of ways, such as through the establishment of Local Implementation Groups within clinical directorates, and through *'time out'* being facilitated to take the initiative forward within local areas. In one organisation the strategic lead is provided by the Trust Quality and Governance Group and Nursing Executive Group. Essence of Care was encompassed as a *'work strand'* in the Trust's strategy for nursing within the *'development of quality patient-centred care'* theme. In another organisation a multidisciplinary steering group was set up and chaired by the Director of Nursing. The Trust Quality Forum then offered support and encouragement to ward areas and led the pilot for the nutrition and communication benchmarks. The Trusts career framework for staff learning and development includes information and guidance on Essence of Care and awareness sessions to support staff in the implementation of the benchmarks are provided.

Question eight asked whether Essence of Care had informed organisational policy, procedures and/or good practice guidelines?

Ten of the eleven responding Trusts indicate this had been achieved in a wide range of ways. In several Trusts for example, the MUST nutritional assessment tool had been introduced and relevant care planning documentation issued in support as part of the food and nutrition benchmark. In other organisations, Essence of Care benchmarking has been integrated into all aspects of clinical and social

care governance resulting in the development of various policies i.e. carer's and visitor's policy. In another Trust the operational policy on the observation of patients with mental health problems had been amended to afford people more privacy whilst ensuring their safety. In a separate initiative policy on preparation of patients for theatre had changed in terms of keeping them warmer and to maintain their dignity through allowing more items of personal clothing to be worn. A separate Trust had undertaken an initiative through developing a *'participation and involvement policy'* which includes a procedure and guidance on involving patients in Essence of Care projects. Another Trust has developed a Trust Visiting Policy that had incorporated learning from the privacy and dignity benchmark.

Question nine asked if there was a team training approach to implementing Essence of Care?

Eight of the eleven Trusts responding had facilitated a team training approach to prepare staff for Essence of Care initiatives. These have included such things as awareness sessions facilitated by the in-service education provider, training workshops for full teams undertaking specific benchmarks and input from specialist staff or professional groups with expertise in an area that complements developments in Essence of Care. Examples of this include training offered by dieticians on areas of relevance to the food and nutrition benchmark.

Question ten asked was there a clear understanding of the benchmarking process and whether it related to sustained quality improvement within the organisation?

Nine of the eleven Trusts claimed that there was a good level of understanding of the benchmarking process. This is interesting considering that most Trusts have found it difficult, for a number of reasons, to roll this work out across and beyond their own services. In addition, respondents in Part 1 of this review were often keen to note

that organisational understanding of and confidence in the benchmarking process is sometimes weak.

A number of examples have been offered by Trusts who state that organisationally there is a good understanding of the benchmarking process. This had been achieved, for example, when Essence of Care had been linked with quality systems and when the governance coordinator had been involved in the process thereby ensuring that the benchmarks were integrated with other quality improvement initiatives. Another Trust had ensured that the Essence of Care benchmarking process was an integral component of the development programme for ward managers. In another example, there were quarterly reports to the governance committee regarding Essence of Care and increasing awareness of the impact of such work on improving patient experience. A separate Trust claims to have established *'a clear understanding of the benchmarking process and how it relates to sustained quality improvement within the organisation. Awareness sessions have been provided to staff across the Trust regarding the benchmarking process and the findings/recommendations of the process have been communicated widely'*.

SECTION FOUR

DISCUSSION AND CONCLUSIONS

4.0 It is evident from the above analysis that the regional effort to implement the Essence of Care benchmarks has been widespread and had a positive effect on the quality of service provision in many areas, and this must be recognised and commended. The findings of this review are comprehensive and provide helpful guidance for those continuing this work or when commencing benchmarking activity in their organisation. The findings can also offer direction for those at a policy and organisational planning level with responsibility for ensuring that initiatives like Essence of Care are embedded in strategy and governance targets. A number of specific findings are worthy of discussion at this stage and in response to the section below, a list of recommendations for future work in this area are presented.

4.1 There is a need to understand better the factors that prevent the rolling out and ongoing evaluation of benchmarking activity. A number of these have been noted throughout this review, such as an apparent lack of time to undertake this work, competing priorities, poor leadership and lack of priority being given to this work at a strategic and operational level. It is clear that the *'time factor'* has a major bearing on the ability to undertake Essence of Care work, even when there is organisational or local service commitment to the process. This alongside other competing demands on quality improvement e.g. meeting hospital cleanliness and infection control targets, will require consideration if Essence of Care is to have lasting impact.

4.2 A lack of confidence in the process organisationally would appear to have been one of the main reasons why Essence of Care was not sustained organisationally or why benchmarking between organisations has rarely occurred. Indication is therefore provided for assessing the level of understanding each organisation has regarding application of

the Essence of Care toolkit, and by considering the training needs people have, the range of facilitation skills available and various other levels of support to enable this work to become effective and commonplace i.e. administration, audit and information/records support. There is therefore a need to ensure that future work in this area is underpinned by a sound educational programme to build confidence in and understanding of this work, in conjunction with expert facilitation and local leadership for the process.

4.3 Given that a number of Trusts acknowledged the challenge of achieving multidisciplinary commitment to undertaking Essence of Care work, it is essential that organisations learn from examples of successful benchmarking practice. There is therefore a need to promote awareness of Essence of Care as a multidisciplinary initiative that involves engagement and participation at a range of professional, planning, service user and administrative levels. Two important ways of achieving this are for organisations to publish the findings of successful benchmarking activity on the NIPEC Development of Practice Database or to access funding e.g. Regional Multiprofessional Audit Group (RMAG) support for audit work connected with Essence of Care. This not only helps to share 'good practice initiatives' but in addition to promoting the sustainability of such efforts can assist organisations to build confidence and capacity in the benchmarking process through pooling resources and enabling those facilitating such work to collaborate during the development of their project work.

4.4 It is clear from the range of improvements offered during the review analysis that small changes have the potential to make a big difference, but only if they have been transferred to other parts of individual organisations and regionally. There is therefore a responsibility for those leading and facilitating Essence of Care to ensure that the outcomes of this work are shared widely. If all of the many positive achievements gained as a result of the reporting for this review were shared, good practice initiatives would have been

enhanced in many areas. Opportunities to utilise the benchmarking toolkit could then have been realised in the way it was designed and originally intended whereby a number of organisations focusing on a specific benchmark, would compare evaluation data, share action plans and monitor the impact of these changes in practice. This would not only help to develop a widespread appreciation of the potential of Essence of Care, but will in doing so build capacity and confidence at the service delivery level in a way that helps practitioners to develop essential skills in quality improvement work. Ways of ensuring there is better organisational commitment will therefore require consideration if this work is to become mainstreamed and thus have the kind of impact on quality and safety of care provision that it has the potential to offer.

4.5 Organisations therefore have a responsibility to promote awareness of the benchmarking process and the opportunities this can bring for improving team working and service delivery. This review provides evidence that if Essence of Care is not seen as a *'high priority'* it is unlikely to be driven from the top of the organisation or given the local commitment it requires. It has been suggested by a number of questionnaire respondents and is evidently clear that in future, Essence of Care will require the regional government drive given to other quality and performance improvement priorities if it is to become regionalised and central to organisational governance work. It is therefore essential to have the benchmarks embedded in DHSSPS Priorities for Action targets, and thus recognised as a well established process for improving the quality of services and as a result patient experience. It is clear therefore that a requirement to challenge attitudes to Essence of Care is evident, as a recommendation from this review and it is likely that if prioritised as a performance target through specific quality indicators, there is a much greater likelihood that organisations, managers and practitioners will implement and sustain the process. There is firm evidence from Northern Ireland and beyond that Essence of Care does improve quality of service provision and patient experience in health and social care. Changing levels of

expectation around this process and by making the benchmarks a regional priority to which organisations are held to account, may stimulate the change in focus that is required to build levels of commitment regionally.

SECTION FIVE

RECOMMENDATIONS

NIPEC aims to improve the quality of health and care by supporting the practice, education and performance of nurses and midwives. We believe Essence of Care is a significant tool to guide and improve the quality and safety of services while contributing to personal learning and development for practitioners, patients and the public. The benchmarking toolkit can provide strong evidence in support of the achievement of HPSS Quality Standards and in addressing fundamental aspects of care in areas such as privacy and dignity the outcomes of this work can contribute to performance indicators around the vital area of improved patient experience.

As a response to this reviews findings and discussion NIPEC make the following recommendations to assist organisations when taking forward future Essence of Care benchmarking work:

1. Each organisation should nominate and resource a dedicated lead for Essence of Care, and in line with this, capacity for local facilitation should be enabled and developed to guide the benchmarking process.

2. Essence of Care should be clearly articulated in DHSSPS Priorities for Action targets for 2008-09 as a recognised and well established method for improving service quality and demonstrating improved patient/public experience. Linked to this Essence of Care should be outlined as an expectation in Trust Delivery Plans and part of the organisational governance framework and quality improvement planning processes.

3. Essence of Care should be recognised and widely reported as an important means of providing evidence in support of achieving performance targets around organisational quality indicators for 'improved patient experience'.

4. Organisations should consider the range of resources required to implement and sustain Essence of Care and ways of enabling this to happen effectively for example; expert facilitation, project time, implementation planning, monitoring and evaluation.

5. A regional awareness programme to promote Essence of Care at a multidisciplinary and service user level is needed, to help develop interest in and recognition of the value of this work in improving the quality of service delivery.

6. Education and training for Essence of Care should be firmly embedded in education programmes and embraced within continuous professional development for practitioners. This should be valued and supported as an important learning and development activity.

7. There is a need to develop a common evaluation template for Essence of Care and communicate widely the range of methods that can be used to monitor, evaluate and demonstrate ways of utilising successful benchmarking activity.

8. Essence of Care leads should take responsibility for communicating their benchmarking work widely, publish this on the NIPEC Practice and Quality Development Database, and develop ways of benchmarking their work with other areas.

APPENDICES

Appendix 1 List of all Projects by Organisation and Benchmark

Name of Organisation	Benchmark
Altnagelvin	Nutrition Pressure Ulcers Privacy and Dignity Personal and Oral Hygiene
Armagh and Dungannon	Nutrition Continence
Belfast City Hospital	Nutrition Safety of Clients with Mental Health Needs
Craigavon Area Hospitals Group Trust	Privacy and Dignity Pressure Ulcers Nutrition
Causeway H&SS Trust	Nutrition Privacy and Dignity Safety of Clients with Mental Health Needs
Craigavon and Banbridge	Continence
Down and Lisburn	Nutrition Pressure Ulcers
Foyle	Nutrition Privacy and Dignity Personal and Oral Hygiene
Greenpark Healthcare Trust	Nutrition Personal and Oral Hygiene Pressure Ulcers
Homefirst	Nutrition Privacy and Dignity Continence Communication
Mater Hospital Trust	Nutrition Communication Privacy and Dignity Pressure Ulcers Personal and Oral Hygiene Continence Safety of Clients with Mental Health Needs Record Keeping Self Care
Newry and Mourne	Record Keeping Continence

Royal Group of Hospitals	Nutrition Communication
Sperrinlakeland	Nutrition Safety of Clients with Mental Health Needs
Ulster Community & Hospitals Trust	Nutrition Safety of Clients with Mental Health Needs
United Hospitals Trust	Pressure Ulcers Record Keeping Nutrition
Marie Curie	Communication Nutrition Privacy and Dignity
Northern Ireland Prison Nursing Service	Self Care
Clonlee Nursing Home	Communication
Four Seasons Health Care – Four Boards	Pressure Ulcers
Kingsway PNH	Record Keeping
Massereene Manor	Communication

Appendix 2 - Part One – Essence of Care Review Questionnaire

(This Table represents projects submitted by the 20 respondents to the Part 1 questionnaire.)

Table 1

Benchmark area	Facilitator/ Project Lead	Month and year this work commenced	Current status of the project	Month and year this work was completed (if appropriate)	How have you evaluated/monitored the impact of this work?
Communication	Caroline Lee RVH	November 04	Ongoing through multidisciplinary focus group meetings with patient representatives	Ongoing	Audit tool developed; limited roll-out of this
	Ann Scott Homefirst (Tardree Two)	September 04	Action plans implemented and ongoing	May 05	Audited September 05; re-audit November 06
	Bernie Mitchell Mater	June 03	Ongoing, through focus on regional and national benchmark	Ongoing	Working with patient support officer and assessing communication issues in complaints monitoring
	S/N McLaughlin Foyle	October 05	Completed and implementing the recommendations	Not stated	Not evaluated or monitored yet

Privacy and Dignity	Carol McCorry Craigavon	September 04	Contained in all education programmes; ward managers are involved in the continued roll out	February 05, but awareness sessions are ongoing	Monitoring feedback from staff; incidence of complaints; QUALPACS (2-hour observation of care)
	Wendy Cross Altnagelvin	October 04	Completed and for review Trustwide in January 07	March 05	For review January 07
	Penny Crawford BCH	March 05	Completed	June 06	Completed and reported at Trust conference
	Ann Scott Homefirst (Tardree One)	September 04	Action plans are ongoing	May 05	Audit September 05/Re-audit November 06
	Pamela Craig Causeway	November 04	Completed	Work continues within teams	Audits, training is monitored, induction policy, satisfaction questionnaire and record audit
	Sr's McGillian and Conlon Mater	February 02	Completed June 03 but now being re-focused upon	June 03	Ongoing through quality tool and complaints monitoring
	Laurie Lancaster Marie Curie Hospice Belfast	November 04	Ongoing	Completed May 06	Audit, user group satisfaction, observations

Privacy and Dignity	Sr Marshall Foyle	June 04	Implemented in all hospital wards	Not stated	Not evaluated – planned for 2007
Personal and Oral Hygiene	Wendy Cross Altnagelvin	February 04	Completed	June 05	Not stated
	Suzanne O'Boyle Mater	October 01	Continuing as a priority area	June 03	Ongoing through use of quality tools and complaints review
	Sr Gormley Foyle	January 04	Not stated	January 05	Not evaluated
Nutrition	Project Leads RVH	November 04	Four MDT Focus group meetings completed	Not stated	Audit tool developed – limited use of due to competing priorities
	Edel Corr Craigavon	August 04	Trust Nutrition Group leading	April 05	Observational surveys, questionnaires, complaints, QUALPACS
	Wendy Cross Altnagelvin	February 04	Completed	June 05	Re-audit 06 – further actions and audits planned
	Ann Scott Homefirst (Inver Four)	September 04	Action planning ongoing	May 05	Audit September 05; re-audit November 06

Nutrition	Pamela Craig Causeway	November 04	Nutrition screening group established Trustwide; also MDT monitoring group	Ongoing	Satisfaction questionnaire, suggestion box, complaints audit, staff training evaluation, review of meals provision, review of hygiene and food choice flexibility
	Sr McWilliams United	September 05	Continues to be rolled out Trustwide	Ongoing	Audit of practice
	Caroline Toal Armagh & Dungannon	2004	Ongoing	Benchmarks in place in all Trust wards	Interfaced with existing audit processes, patient satisfaction survey on meal provision
	Sr Alcorn Foyle	April 04	Not stated	April 05	Not evaluated
	Margaret Moore Down Lisburn	June 04	Continues	Ongoing	Satisfaction survey, better dietetic input, protected meal times, display board, better selection
	Mary McElroy Mater	February 02	Ongoing as part of Trustwide review and monitoring	Ongoing	Regular monthly meetings of the quality circle group for nutrition with full MDT involvement
	Annetta Quigley Sperrin Lakeland	June 04	Ongoing	June 05 but ongoing	Spot checks of protected meal times, use of MUST tool to be evaluated

Nutrition	Marie Morrisey Marie Curie Hospice Belfast	November 04	Ongoing	Completed May 06	Audit, user group satisfaction, observations
Benchmark area	**Facilitator/ Project Lead**	**Month and year this work commenced**	**Current status of the project**	**Month and year this work was completed (if appropriate)**	**How have you evaluated/monitored the impact of this work?**
Self Care					
Pressure Ulcers	Christine Armstrong Craigavon	August 04	Findings and recommendations issued to all ward managers	February 05	Monitored by dermatology/tissue viability service team through point prevalence study
	Lee Edmonds Four Seasons	2004/05	16 out of 26 recommendations implemented, others ongoing	February 05	Quarterly audits by tissue viability nurse. Monthly audits by home manager and regional manager
	Sandra Bellingham Causeway	Recently commenced			
	Lorna Semple Mater	February 02	Constantly under review, led by tissue viability nurse	2003 but ongoing	Tissue viability nurse evaluates the whole service using the Essence of Care principles

Pressure Ulcers	Sr Reid Foyle	October 05	Completed, recommendations being implemented	October 06	Not evaluated
Record Keeping	Ann Scott Homefirst Whiteabbey Day Hospital and Magherafelt Community Mental Health Team	January 06	Action plans implemented and work ongoing	August 06	Re-audit planned for August 07
	Jacqueline Clarke Newry & Mourne	March 04	Ongoing	Ongoing	Through working and steering group
	Sr Parker Foyle	October 05	Completed, recommendations in progress	October 06	Not evaluated
Safety of Clients with Mental Health Needs	Hugh Scullion BCH	November 04	Completed	June 06	Commencement of groups with responsibility for information and policy review
	Eileen Gailey Causeway	September 05	Work remains ongoing	Some parts of the action plan have been completed	Audit of nursing process, patient satisfaction questionnaire, review of policies and procedures is underway

Safety of Clients with Mental Health Needs	Damien Brannigan Ulster & Community Hospital	August 05	Completed	June 06	Work continue but isn't referred to as Essence of Care
Continence, Bladder and Bowel Care	Mary McConville Craigavon & Banbridge	March 04	Completed	May 05	Review of waiting times, monitoring of attendances, review numbers waiting first appointment, education for staff who work with children
	Teresa McEvoy Mater	February 02	Now integrated alongside the ongoing work to meet the standards set out in the national audit of continence for older people	June 03	Hasn't been robustly evaluated so far, but aiming to
	Jacqueline Clarke Newry & Mourne	March 04	Ongoing	Not stated	Through working group and steering group
	Caroline Toal Armagh & Dungannon	2004	Postponed due to inability to recruit a continence nurse to lead the work		
Promoting Health					

In relation to the original benchmarking projects commenced prior to 2005, what have been the **'most successful features'** of this work? (Please list these below, providing any information and/or named contacts that would help to evidence this claim)

1.
2.
3.
4.
5.

Please list and describe any **'challenges'** you have experienced as an organisation in relation to the successful establishment, implementation and sustainability of Essence of Care Benchmarking in the original project areas (please provide as much information as you can to evidence this, and contact details for further discussion in specific areas would be helpful)

1.
2.
3.
4.
5.

Are there any particular **'issues'** that require development work, to enable you as an individual project lead, your practice area, or as an organisation to take forward Essence of Care work across each of the original benchmark areas?

1.
2.
3.
4.
5.

Appendix 3 – Part Two Essence of Care Review Questionnaire

Please complete the following questionnaire, providing detail wherever possible:

1. How satisfied have you been with the progress of the Essence of Care Benchmarking work undertaken in your organisation?

   Very satisfied □

   Satisfied □

   Dissatisfied □

   Very dissatisfied □

Details:

_____

_____

2. What were the **'main challenges'** you faced regarding the introduction and implementation of Essence of Care benchmarks?

Details:

_____

_____

3. Have you been able to expand Essence of Care project work across your organisation, from the time of reporting progress against the original benchmarks in May 2005 (detailed in Part 1 of this Review)?

Yes □

No □

If you answered Yes, how have you expanded or taken this work forward'?

Details:

If you answered No, why has this not been possible?

Details:

4. Is Essence of Care benchmarking work **'required'** in each of the following areas?

a) Listed in your own objectives as a Director of Nursing - Yes □ No □
b) Listed as Priorities for Action targets by the Trust - Yes □ No □
c) Prioritised within the Trust Delivery Plan and performance management arrangements - Yes □ No □
d) Part of the clinical governance framework within the organisation - Yes □ No □
e) Part of the organisations quality improvement plan/clinical audit programme - Yes □ No □
f) Part of the risk management programme within your organisation - Yes □ No □

5. Who has led Essence of Care Benchmarking in your organisation?

Name:

Position:

6. Has Essence of Care work involved participation and project working across the multi-disciplinary team?

Yes □

No □

If Yes, which areas have undertaken this successfully:

7. Please describe the type of organisational support given towards establishing Essence of Care?

Details:

8. Has Essence of Care Benchmarking informed organisational policy, procedures, practice guidelines?

Yes ☐

No ☐

Detail:

_____

_____

9. Is there a team '**training**' approach to implementing Essence of Care?

Yes ☐

No ☐

Detail:

_____

_____

10. Is there a clear understanding of the benchmarking process and how it relates to sustained quality improvement within the organisation?

Yes ☐

No ☐

Details:

Have you any other comments in relation to Essence of Care progress?

Thank you for taking the time to complete this questionnaire. I would be grateful if you could now indicate using the table below the current status of particular benchmarking activity in your organisation.

Part 2 – Essence of Care Review Questionnaire: Please indicate which areas are currently active in your organisation, and give appropriate detail as requested:

Benchmark area	If this is currently being benchmarked in your organisation, please indicate which clinical area/specialty is working on this and who is leading this work
Communication	Royal Group of Hospitals HSST – Lead is Janice Flanagan Foyle HSST: Waterside Hospital – Lead is S/N McLaughlin Mater Hospital Trust: Ward A – Lead by Sister Grainne McFetridge Mater Hospital Trust: Ward E – Lead by Sister Brenda Burke
Privacy and Dignity	Armagh & Dungannon HSST: Outpatients Department, Armagh Community Hospital – Lead is Loretto Fegan, Practice Development Nurse and Key Facilitator is Sr Maura Murphy Craigavon Area Hospital Group Trust – Lead is Carol McCorry (Practice Development Facilitator) Royal Group of Hospitals HSST – Within CaVaTs only – Lead is Sister Karen James Foyle HSST: Waterside Hospital – Lead is Sister Marshall Mater Hospital Trust: A&E – Lead by Sister Rae Conlon
Personal and Oral Hygiene	Royal Group of Hospitals – Within CaVaTs only – Lead is Sister Karen James Belfast City Hospital Trust: Level 6 – Lead is Sister Veronica Mullan Foyle HSST: Waterside Hospital – Lead is Sister Canavan Mater Hospital Trust: Ward B – Lead by Sister Lynda Orr Mater Hospital Trust – Lead by Bridgene Bradley (Palliative Care Nurse)

Nutrition	Armagh & Dungannon HSST: All in-patient wards in the Trust including care of the elderly, mental health and learning disability facilities – Lead is Loretto Fegan (Practice Development Nurse) and Ashleigh Nelson (Nutrition and Dietetic Service Manager) Craigavon Area Hospital Group Trust – Lead is Edel Corr (Quality and Patient Support Manager) Royal Group of Hospitals HSST – Lead is Jenny Stevenson; Also within CaVaTs through Sister Karen James Down Lisburn HSST – Lead by Margaret Moore (Principle Nurse) and Ward Manager Belfast City Hospital Group Trust – Lead by Sister Olivia McManus (ERU), Sister Theresa Cushley (Ward 22), and Sister Valerie Bell (Specialist Nurse in Cystic Fibrosis) Newry and Mourne HSST: Medical Directorate – Lead by Dorothy Dooley (Assistant Director of Nursing) United Hospitals Trust: Ward 1 Mid-Ulster Hospital (Surgical Ward) – Lead by Sister McWilliams Foyle HSST: Waterside Hospital – Lead is Sister Alcorn Mater Hospital Trust – Lead by Bernie Mitchell (Patient Support Officer)
Self Care	
Pressure Ulcers	Craigavon Area Hospital Group Trust – Lead is Christine Armstrong (Practice Development Facilitator) Royal Group of Hospitals HSST: A&E – Lead is Dianna Gillespie; Also in CaVaTs through Sister Karen James Down and Lisburn HSST – Lead by Tissue Viability Team Foyle HSST: Waterside Hospital – Lead is S/N Reid

Record Keeping	Armagh & Dungannon HSST: All nursing areas within the Trust – Lead is Loretto Fegan (Practice Development Nurse) Royal Group of Hospitals HSST – Lead by Caroline Lee Newry and Mourne HSST – Lead by Jacqueline Clarke (Practice Development Facilitator) Foyle HSST: Sister Giblin, Ballycann Assessment Unit, Gransha
Safety of Clients with Mental Health Needs	Armagh & Dungannon HSST: Wards 3 and 6 St. Lukes Hospital – Lead is Loretto Fegan (Practice Development Nurse) and Bernadette Corvan (Clinical Services Manager) Newry and Mourne HSST: General Medical and Surgical Wards plus A&E – Lead by Ronan Carroll (Assistant Director of Nursing)
Continence, Bladder and Bowel Care	Newry and Mourne HSST – Lead by Jacqueline Clarke (Practice Development Facilitator)
Promoting Health	

Thank you for completing this questionnaire. Please send your return to the email address below by Friday 16th February.

Bob Brown

Senior Professional Officer (Practice and Quality)

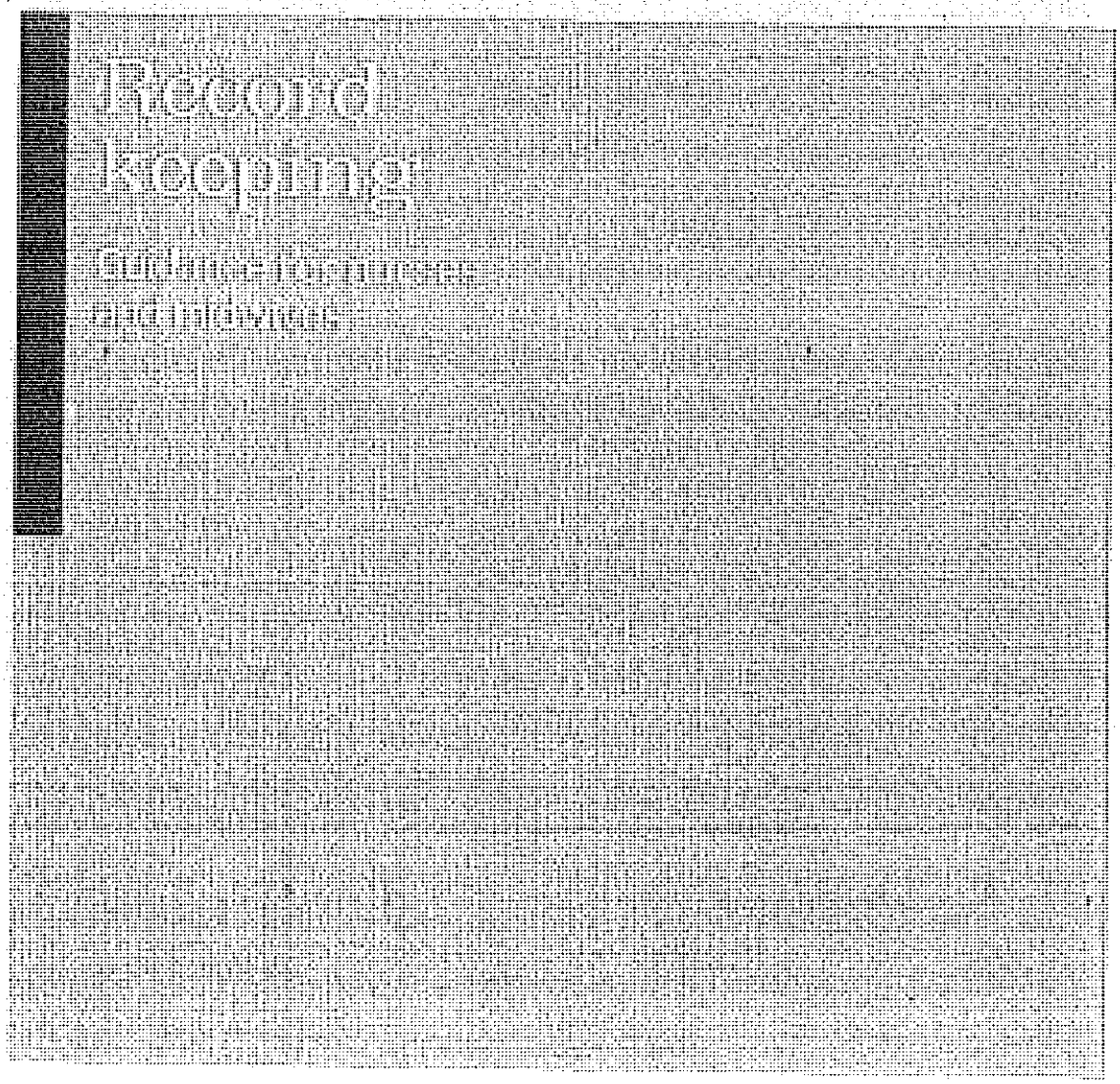
NIPEC

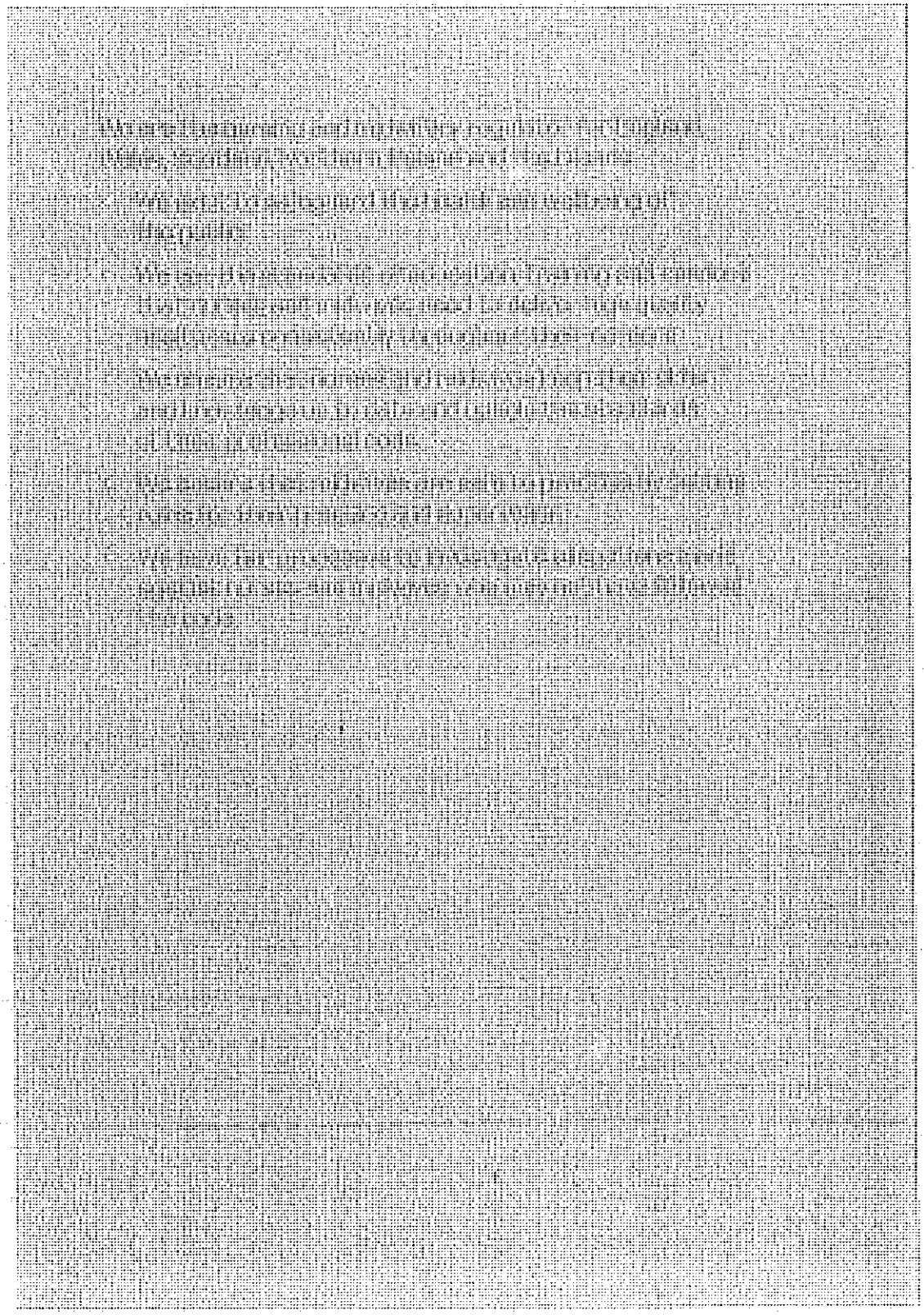
bob.brown@nipec.n-i.nhs.uk

Appendix 4 – Potential regional impact of benchmarking work on privacy and dignity should this 'best' practice be applied in all areas

1. Production of a more dignified gown for women attending the Breast clinic
2. Updating of the Trust visiting policy with learning from the privacy and dignity benchmark applied
3. Opaque covering applied to vented windows in the Maternity Unit Delivery Suite to improve privacy
4. Policy on the preparation of patients for theatre has now changed in terms of allowing more items if clothing to be worn to improve dignity and prevent heat loss
5. Policy on the observation of clients with mental health problems has been amended to afford people more privacy, whilst ensuring their dignity.

Nursing & Midwifery Council





Record keeping: Guidance for nurses and midwives

The way in which nurses and midwives keep records is usually set by their employer. The Nursing and Midwifery Council (NMC) recognises that, because of this, nurses and midwives may use different methods for keeping records. However, the principles of good record keeping are well established, and should reflect the core values of individuality and partnership working.

Good record keeping is an integral part of nursing and midwifery practice, and is essential to the provision of safe and effective care. It is not an optional extra to be fitted in if circumstances allow.

National programmes for the use of information communication technology and electronic record keeping are being introduced throughout the UK. Although electronic records are evolving, it is clear from nurses and midwives that paper-based records are still commonly used. This guidance applies to both paper and electronic records. It explains what we expect from all nurses and midwives.

Good record keeping, whether at an individual, team or organisational level, has many important functions. These include a range of clinical, administrative and educational uses such as:

- helping to improve accountability
- showing how decisions related to patient care were made
- supporting the delivery of services
- supporting effective clinical judgements and decisions
- supporting patient care and communications
- making continuity of care easier
- providing documentary evidence of services delivered
- promoting better communication and sharing of information between members of the multi-professional healthcare team
- helping to identify risks, and enabling early detection of complications
- supporting clinical audit, research, allocation of resources and performance planning
- helping to address complaints or legal processes.

The Data Protection Act 1998 defines a health record as "consisting of information about the physical or mental health or condition of an identifiable individual made by or on behalf of a health professional in connection with the care of that individual".

The principles of good record keeping apply to all types of records, regardless of how they are held. These can include:

- handwritten clinical notes
- emails
- letters to and from other health professionals
- laboratory reports
- x-rays
- printouts from monitoring equipment
- incident reports and statements
- photographs
- videos
- tape-recordings of telephone conversations
- text messages.

Principles of good record keeping

1 Handwriting should be legible.

2 All entries to records should be signed. In the case of written records, the person's name and job title should be printed alongside the first entry.

3 In line with local policy, you should put the date and time on all records. This should be in real time and chronological order, and be as close to the actual time as possible.

4 Your records should be accurate and recorded in such a way that the meaning is clear.

5 Records should be factual and not include unnecessary abbreviations, jargon, meaningless phrases or irrelevant speculation.

6 You should use your professional judgement to decide what is relevant and what should be recorded.

7 You should record details of any assessments and reviews undertaken, and provide clear evidence of the arrangements you have made for future and ongoing care. This should alsoinclude details of information given about care and treatment.

8 Records should identify any risks or problems that have arisen and show the action taken to deal with them.

9 You have a duty to communicate fully and effectively with your colleagues, ensuring that they have all the information they need about the people in your care.

10 You must not alter or destroy any records without being authorised to do so.

11 In the unlikely event that you need to alter your own or another healthcare professional's records, you must give your name and job title, and sign and date the original documentation. You should make sure that the alterations you make, and the original record, are clear and auditable.

12 Where appropriate, the person in your care, or their carer, should be involved in the record keeping process.

13 The language that you use should be easily understood by the people in your care.

14 Records should be readable when photocopied or scanned.

15 You should not use coded expressions of sarcasm or humorous abbreviations to describe the people in your care.

16 You should not falsify records.

Confidentiality

17 You need to be fully aware of the legal requirements and guidance regarding confidentiality, and ensure your practice is in line with national and local policies.

18 You should be aware of the rules governing confidentiality in respect of the supply and use of data for secondary purposes.

19 You should follow local policy and guidelines when using records for research purposes.

20 You should not discuss the people in your care in places where you might be overheard. Nor should you leave records, either on paper or on computer screens, where they might be seen by unauthorised staff or members of the public.

21 You should not take or keep photographs of any person, or their family, that are not clinically relevant.

Access

22 People in your care should be told that information on their health records may be seen by other people or agencies involved in their care.

23 People in your care have a right to ask to see their own health records. You should be aware of your local policy and be able to explain it to the person.

24 People in your care have the right to ask for their information to be withheld from you or other health professionals. You must respect that right unless withholding such information would cause serious harm to that person or others.

25 If you have any problems relating to access or record keeping, such as missing records or problems accessing records, and you cannot sort out the problem yourself, you should report the matter to someone in authority. You should keep a record that you have done so.

26 You should not access the records of any person, or their family, to find out personal information that is not relevant to their care.

Disclosure

27 Information that can identify a person in your care must not be used or disclosed for purposes other than healthcare without the individual's explicit consent. However, you can release this information if the law requires it, or where there is a wider public interest.

28 Under common law, you are allowed to disclose information if it will help to prevent, detect, investigate or punish serious crime or if it will prevent abuse or serious harm to others.

Information systems

29 You should be aware of, and know how to use, the information systems and tools that are available to you in your practice.

30 Smartcards or passwords to access information systems must not be shared. Similarly, do not leave systems open to access when you have finished using them.

31 You should take reasonable measures to check that your organisation's systems for recording and storing information, whether by computer, email, fax or any other electronic means, are secure. You should ensure you use the system appropriately, particularly in relation to confidentiality.

Personal and professional knowledge and skills

32 You have a duty to keep up to date with, and adhere to, relevant legislation, case law, and national and local policies relating to information and record keeping.

33 You should be aware of, and develop, your ability to communicate effectively within teams. The way you record information and communicate is crucial. Other people will rely on your records at key communication points, especially during handover, referral and in shared care.

34 By auditing records and acting on the results, you can assess the standard of the record keeping and communications. This will allow you to identify any areas where improvements might be made.

Further reading

This guidance is supported by further notes and frequently asked questions, along with the NMC advice sheet *Confidentiality* (2009), which are available at www.nmc-uk.org

Further information can be found in the following documents and publications which are available on various external websites.

- National Health Service (Venereal Disease) Regulations (SI 1974/29)
- Access to Health Records Act 1990
- Computer Misuse Act 1990
- Civil Evidence Act 1995
- The Caldicott Committee Report on the Review of Patient-Identifiable Information, Department of Health (1997)
- Access to Medical Reports Act 1998
- Data Protection Act 1998
- Human Rights Act 1988
- Road Traffic Act 1998
- Data Protection (Processing of Sensitive Personal Data) Order 2000

- Electronic Communications Act 2000
- Freedom of Information Act 2000
- Freedom of Information (Scotland) Act 2002
- Communications Act 2003
- Confidentiality: NHS Code of Practice (2003)
- Information Security Management: NHS Code of Practice (2007)
- NHS Information Governance: Guidance on Legal and Professional Obligations (2007)
- Counter-Terrorism Act 2008
- Human Fertilisation and Embryology Act 2008
- Records Management: NHS Code of Practice (Scotland) Version 1.0 (2008)

This guidance on record keeping was published in July 2009, for implementation from 1 August 2009. It replaces *Guidelines for records and record keeping* (NMC 2002) and the *NMC advice sheet on record keeping* (NMC 2007).

The current design was introduced in April 2010, however the content has not changed.

Further information to support this guidance is available on our website, www.nmc-uk.org

This guidance will be reviewed in 2012.